

ined, and the method in which it should be given—viz., in small doses at short, but regular, intervals—is pointed out. Alcohol should be regarded, as has been remarked by Dr. Todd, not as a specific remedy, but simply as a kind of food. It is really a hydrocarbon, very easy of digestion, possessing certain properties of enabling the body temporarily to withstand exhausting influences, and capable, by its undergoing oxidation in the system, of maintaining the animal temperature, and of preventing waste of tissue. The *modus operandi* of the remedies usually employed in croup is then discussed, and their real value indicated, and the error of supposing this disease to consist in ordinary inflammation of the windpipe is alluded to; and, while the inefficiency of the remedies commonly used in croup is pointed out to be such as theory would lead us to expect, the same fact is shown practically by the results of experience, which clearly indicate that under all plans of treatment, exclusive of tracheotomy, croup is a very fatal malady. The value of emetics is also examined, and the danger which frequently results from the employment of tartar emetic is dwelt upon.

The circumstances which tend to diminish the chances of success from tracheotomy are then referred to under the following heads:—

- a. The age of the patient.
- b. The existence of pneumonia or bronchitis.
- c. The presence of other diseases, such as measles, whooping-cough, &c.
- d. The employment of depressing remedies prior to the operation.
- e. The postponement of tracheotomy until the patient is *in extremis*.
- f. The extension of the croupous exudation into the lungs.

After suggesting a few practical hints in connection with the operation itself, and in regard to the inhalation of chloroform in these cases, and after briefly glancing at the various points which have been examined in detail, the author thus concludes: It only remains to warn the practitioner against expecting a large share of success from this operation, inasmuch as in our present inability to ascertain whether the croupous exudation is limited to a small portion of the windpipe, or whether it extends into the minute branches of the bronchial tree, we must necessarily oftentimes recommend its performance in cases in which death must almost inevitably take place. But while a careful examination of this subject clearly indicates the propriety of making an opening into the trachea in those cases of croup in which false membrane exists, and of not postponing the operation until the last moment, and while it leads to the anticipation of a decided diminution in the rate of mortality from this disease when the early performance of tracheotomy is extensively practised, the student of science cannot but feel that tracheotomy is at best but an expedient of relief, capable, by its mechanical action, of obviating certain tendencies to death, and, by enabling the administration of support to an exhausted system of affording time for the due occurrence of certain processes necessary to recovery. Nor can the practical physician forget that some effectual remedy for croup has still to be searched for, not to be found in all probability until the true etiology and pathology of the disease are far better understood than at the present day. At the same time it is impossible to foretell how near at hand the day may be when there shall be found a man who will do for croup what Jenner did for smallpox, or when there shall be discovered a remedy for this malady as certain in its power, and as efficacious in its action, as is iodide of potassium in syphilitic periostitis, or as is quinine in ague.

22. *Incisions in Anthrax*.—MAURICE H. COLLIS, Surgeon to Meath Hospital, says (*Dublin Quarterly Journ. Med. Sciences*, August, 1859) that “the incision into anthrax, whether made early or delayed till sloughing has done part of the surgeon’s work, must be deep rather than extensive. Usually it is said anthrax is a flat swelling. The fact of its flatness, or rather of its extent, hides the real amount of elevation, which is, in most cases, considerable. Hence incisions into anthrax seldom go down *through* the inflamed skin and areolar tissue. But even if they did go down to the fascia, they would fail in effect unless they also went through it. The fascia is highly inflamed in anthrax; in fact the essential difference of anthrax from furuncle consists in the inflammation being deeper and implicating the fascia. When fascia is inflamed, much plastic exudation

takes place, both in its substance and under it; and the tendency of anthrax to spread indefinitely is to be thus accounted for. The pent-up plasma, quickly producing pus and slough, can get no vent until there is an adequate opening in the fascia, and this opening should be made by the surgeon as early as possible, if he would avoid the unpleasantness of useless and repeated cutting, and the extensive sloughing which will occur if he neglect to make it. Plastic exudations find great facility in travelling under the fascia, dissecting and destroying its vascular connections, and ultimately causing much of it to perish. This is well known, as a general principle of surgery, and it is strange to find it overlooked as the cause of the spread of anthrax. We readily acknowledge the mischief it does in periostitis, in diffused inflammations of erysipelatous character or connected with paronychia, and in many other analogous cases; but books of surgery are, for the most part, silent about it in the case of anthrax. And yet every one must have observed phenomena which can only be explained by it. The extent and mode of extension of the swelling, the real depth to which the surgeon must cut if he is to do good rather than harm, and the fact of large flakes of fascia ultimately coming away as dead core (in addition to areolar tissue), leaving the underlying muscles bare, must have been often observed, and must often, doubtless, have had their influence on the practical observer; but the junior surgeon and the pupil have not been shown their practical bearing. The rule I have given above, to cut deep rather than wide, is founded on the observation of these facts, and will be found satisfactory, saving the surgeon the opprobrium of cutting twice or oftener without benefit to his patient. It is very easy to know when we are deep enough; by taking hold of the flaps made by our crucial incision, we feel if they are quite loose. Our incision is not deep enough unless we can lift up the point of each flap with ease from the parts underneath. This cannot be done unless our knife has gone through the fascia, and made a crucial incision in it almost as extensive as in the skin. The wounds we have made should be almost as deep at their extremities as in the centre, where they intersect. If we have made our incisions early, before actual sloughing has commenced, as we sometimes, though rarely, have an opportunity of doing, the flaps will curl up if the wound is deep enough, and will leave a widely gaping wound; but if we do not see the anthrax until more or less of the skin is undermined and dead, the gaping of the wound will not be so marked, and the best test is the one I have given above, of lifting the flaps with a forceps, and proving that they are loose. If this rule is followed, we shall have few cases in which we must come and cut again.

23. *Difficulties attending upon the Treatment of Strictures of the Urethra.*—Mr. HENRY SMITH, in a recent paper (*Med. Times and Gaz.*, August 13, 1859), called attention to a difficulty in the treatment of stricture of the urethra, which consists in the absence of improvement in the power of passing the urine, although dilatation has been carried on in a satisfactory manner. "This is a difficulty," he remarks, "which is exceedingly annoying and distressing, because, in the first place, the patient naturally expects that relief will be given so soon as an instrument of at least a moderate size can be introduced into the urethra, and the surgeon knows that he has to deal with a feature in the complaint which may depend upon circumstances over which he has little control, and which will render the treatment of the case more troublesome. Mere density or tightness in a stricture acting as a bar to progressive dilatation, is a condition much less likely to hinder a satisfactory termination than the one alluded to; for in the one case, although the dilatation may advance but slowly, the improvement in the stream of urine is generally commensurate with the mechanical progress, and satisfactory both to patient and attendant, while in the other it will happen that the exercise of the utmost skill and endurance is but faintly rewarded.

"Next to extreme irritability of the urethra, this one feature of absence of improvement in the stream, has been a source of greater difficulty and annoyance than anything else. Among a considerable number of very severe cases of stricture which have lately been under my care, my attention has therefore been much directed towards ascertaining its cause, and removing the symptom, if it may be so termed. In some cases it has not been difficult to account for it,